Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH ASSOCIATES

Respondent Name
HARTFORD INSURANCE COMPANY

MFDR Tracking Number
M4-11-2330-02

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I placed a call to the adjuster (Melodinne Wood), who was on medical leave, and connected with her Team Lead, Mandy. Mandy notified me the denial for no preauthorization was based on an IME performed on 11/4/10, which indicated 'no further treatment was medically necessary.'... Preauthorization was obtained based on 'medical necessity.'... At this time I ask that you please review the attached documentation and re-process for payment."

Amount in Dispute: $1,530.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see attached PLN-11 denial for pain mgmt as diagnoses carrier excepted in accordance with CCH order were resolved as of 11/4/10, per IME report. Lease see attached."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2011 and January 20, 2011	97799-CP x 9 hours per date of service	$1,530.00	$1,530.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - 198 – Procedure not approved by pre-authorization.

Issues

1. Did the insurance carrier raise the issue of during the bill review process for the disputed charges?
2. Did the requestor obtain preauthorization for the disputed chronic pain management services in dispute?
3. Is the requestor entitled to reimbursement for dates of service January 19, 2011 and January 20, 2011?

Findings

1. To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code § 133.240(e), (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical billing process, when the insurance carrier determined that the medical service was not related to the compensable injury: 31 TexPeg 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified: Former 133.240(e), (e)(1), (2)(C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division .... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title ,... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

   The insurance carrier submitted insufficient documentation (explanation of benefits) to support the denial of compensability, extent-of-injury and/or liability raised in the position summary to MFDR.

2. The requestor seeks reimbursement for non-CARF accredited chronic pain management services rendered on January 19, 2011 and January 20, 2011 as indicated on the CMS-1500 noting CPT code 99799-CP.

   28 Texas Administrative Code §134.600 (p)(10), states "Non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation."

   The insurance carrier issued a preauthorization approval on January 11, 2011 for chronic pain management x 10 days, with a start date of January 10, 2011 and an end date of March 14, 2011.

   28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   A review of the submitted medical bill indicates that the requestor rendered 9 hours of CPT code 97799-CP on January 19, 2011 and January 20, 2011. The disputed charges did not contain a –CA modifier to identify that the services are CARF accredited. As a result, the disputed charges are paid at 80 percent of the MAR.

3. 28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs;

   (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

   (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   Review of the medical documentation submitted by the requestor for date of service January 19, 2011 documents that 9 hours were rendered, as a result the requestor is entitled to 9 hours for this date of service.

   Review of the medical documentation submitted by the requestor for date of service January 20, 2011 documents that 9 hours were rendered, as a result the requestor is entitled to 9 hours for this date of service.

   The reimbursement is therefore calculated per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B).

4. Per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%).

   Date of service January 19, 2011, the requestor billed and documented 9 hours of chronic pain management x $100.00/hour = a MAR amount of $900.00.

   Date of service January 20, 2011, the requestor billed and documented 9 hours of chronic pain management x $100.00/hour = a MAR amount of $900.00.

   The total MAR amount is $1,800.00, the requestor seeks $1,530.00, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,530.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,530.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 26, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.